Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: J.A. McNally, M.D. 4275 Little Rd #202 Arlington, TX 76016	MFDR Tracking #: M4-04-6892-01 DWC Clai Injured En
Respondent Name and Box #: Pacific Employers Insurance Co. Rep Box: 15	Date of Inj Employer Insurance

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DO

Requestor's Position Summary; taken from the Table of Disputed services: "Carrier has denied reimbursement for P4 modifier stating documentation does not support it. It is clearly documented that patient is mobidly(sic) obese and the diagnosis for this is on the HCFA. Venipuncture was denied as global to the anesthesia. Sent a REQUEST FOR RECONSIDERATION and carrier maintains their position."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $110.00
3. CMS 1500
4. EOB

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The bills in question has been paid according to fee guidelines as noted by ACCUMED. Reconsideration was given and no additional payments were recommended."

Principle Documentation:

1. Response to DWC 60
2. Position Statement

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Due
06/02/03	00670-P4	F	1-5	$80.00
06/02/03	36410	G	1-5	$00.00
Total Due:				$80.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under procedure code 00670-P4 and 36410 for DOS 06/02/03.

2. This service was denied by the Respondent with denial reasons:

- G - "Included in global charge"
- F – "Reduction according to medical fee guideline. Review message(s) : >Heavy smoking, hypotension or obesity alone do not quality as severe systemic diseases."

3. Per Rule 134.202(b), CPT code 36410 is considered to be a component procedure of CPT code 00670 for date of service 06/02/03. A modifier is allowed in order to differentiate between the services provided. The requestor's CMS-1500 does not indicate this procedure code was billed with a modifier; therefore, separate payment for the service billed are not considered justifiable.

   Therefore, according to Rule 134.202(c) (1) the requestor is not entitled to additional reimbursement.

4. The Requestor billed the procedure code 00670 with the modifier P4. The P4 modifier is informational to identify the detail of the claim and does not impact reimbursement. The reimbursement for procedure code 00670 is as follows:

   275minutes ÷ 15 = 18.33 units = 18.3
   CPT code 00670 base units = 13 + 18.3 = 31.30 units
   $45.98(conversion factor) x 31.30 units = $1439.17(MAR)
   $1439.17 – $1280.00(carrier paid) = $159.17

5. Therefore, according to Rule 134.202(d) (2) additional reimbursement of $80.00 is recommended.

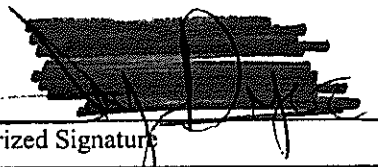
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $80.00 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER :



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01/25 /08

Authorized Signature | Medical Fee Dispute Resolution Officer | Date

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.